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Nos. 02-1845, 03-83

IN THE

Supreme Court of the United States

AETNA HEALTH INC.,
Petitioner,

v.

JUAN DAVILA,
Respondent.

CIGNA HEALTHCARE OF TEXAS, INC.,
Petitioner,

v.

RUBY R. CALAD, *et al.*,
Respondents.

On Writs of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF FOR NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS AS AMICUS CURIAE SUPPORTING RESPONDENTS

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INTEREST OF AMICUS CURIAE

The National Alliance for Model State Drug Laws (hereinafter "National Alliance") is an organization that exists as a resource for governors, state legislators, district attorneys, attorneys general, drug and alcohol abuse prevention and addiction treatment professionals, the recovering community, and others striving for comprehensive and effective drug and alcohol control laws and policies. The National Alliance receives funding from the United States Congress, *see* H.R.J. Res. 2, 108th Cong. (2003), and is the institutional successor to the President's Commission on Model State Drug Laws (the "President's Commission"). The President's Commission, which was established by the United States Congress in the early 1990's, was charged with a number of missions, including the creation of a model code of laws that would help states effectively address alcohol and drug abuse and addiction. *See* PRESIDENT'S COMMISSION ON MODEL STATE DRUG LAWS – TREATMENT at 1 (1993) (hereinafter "PRESIDENT'S COMMISSION - TREATMENT"). The National Alliance continues the work of the President's Commission.

The National Alliance has an interest in this matter because it has concluded that it is vital to preserve the rights of states to pursue effective and cost-saving policy solutions with respect to drug and alcohol control laws.[1]

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[1] No counsel for any party authored this brief, in whole or in part, and no person or entity other than the National Alliance has made a monetary contribution to the preparation or submission of this brief. This *Amicus Curiae* brief is filed pursuant to the written blanket consents that have been filed by the parties.

SUMMARY OF ARGUMENT

The National Alliance urges caution, when this Court considers the preemptive reach of ERISA. States are, and must continue to be, free to adopt effective and cost-effective drug laws and health laws, and this necessarily includes measures to enforce those laws, lest those laws become empty gestures.

ARGUMENT

I. This Court Has Repeatedly Acknowledged the Rights of States to Make Health Policy Decisions.

This Court has in the past consistently preserved the rights of states to enact and enforce those laws that states deem necessary to protect the rights of their citizens. This is particularly true of state laws in the field of health care. *See, e.g., Pegram v. Herdrich*, 530 U.S. 211, 237 (2000) ("[I]n the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose."); *Metropolitan Life Ins. Co. v. Mass.*, 471 U.S. 724 (1985) (state's mandatory mental-health benefit law not preempted by ERISA, except with respect to self-insured plans); *Kentucky Ass'n of Health Plans v. Miller*, 538 U.S. 329 (2003) (state any-willing-provider law not preempted by ERISA); *Rush Prudential HMO v. Moran*, 536 U.S. 355 (2002) (state independent-review law not preempted). The mission and mandate of the National Alliance include not only the study of diseases of addiction, but also the consideration and creation of policy solutions, many of which are embodied in Model State Drug Laws, which were first promulgated by the President's Commission and are now promoted by the National Alliance. This Court's prior decisions have afforded states the policy space to create, pursue, and enforce such solutions, and the National Alliance urges the Court to preserve the freedom of the states in this area.

II. The Benefits of Addiction Treatment

A. Treating Diseases of Addiction Saves Money, Furthers Public Health and Safety, and Is Sound Policy.

Diseases of addiction afflict a significant percentage of the population in this country. For example, a review article in the New England Journal of Medicine reported that "epidemiologic studies in the United States estimate the prevalence of alcohol abuse and dependence in the past year as 7.4 percent to 9.7 percent, and the lifetime prevalence as 13.7 percent to 23.5 percent." Patrick O'Connor, M.D., M.P.H. & Richard J. Schottenfeld, M.D., *Patients with Alcohol Problems*, 338 NEW ENGLAND JOURNAL OF MEDICINE 592, 593 (Feb. 26, 1998) (citations omitted). Diseases of addiction can devastate not only the lives of those directly afflicted, but also the lives of others with whom they share homes, workplaces, cities, and roadways.

Those suffering from diseases of addiction, and their families, use health care (and incur health care costs) at rates significantly higher than the general population. According to a comprehensive review article prepared for the President's Commission, "[i]n contrast to non-alcoholics, alcoholics usually incur health care costs that are at least 100% higher, and in the last twelve months before treatment of addiction, the costs are close to 300% higher." CENTER FOR ALCOHOL STUDIES, SOCIOECONOMIC EVALUATIONS OF ADDICTIONS TREATMENT at i (1993). This increased health care utilization includes use by family members: "[p]olicyholders in alcoholic families use[] roughly twice the [health care] services of nonalcoholic families." *Id.* ch. 4 at 21. Of course, many of the social and economic costs of addiction are then borne by the health care system itself, and by government.

When diseases of addiction are treated, however, health care costs are markedly reduced, for both addicts and their families. SOCIOECONOMIC EVALUATIONS OF ADDICTIONS TREATMENT at i, ch. 4 at 26; *see also* Stephen P. Melek, Research Report: Behavioral Healthcare Risk-Sharing and Medical Cost Offsets 8 (Milliman & Robertson 1996) (describing "important evidence that treatment initiation may result in a decline in overall [health care] costs"), *available at* http://www.milliman.com/health/publications/ research_reports /hr_13.pdf. Thus, treating diseases of addiction is an important and effective way to control health care spending.

Equally significantly, perhaps of paramount importance, treating diseases of addiction is an important way to control and limit the social costs that are imposed on society by these diseases. Roughly 80% of those incarcerated in this country are either chemically dependent or serving time for a crime committed while under the influence of drugs or alcohol. Furthermore, according to a report from the United States Department of Health and Human Services, treating someone suffering from a disease of addiction causes a 79% reduction in crimes that would otherwise be committed by the individual, and therefore a 79% reduction in the costs associated with crime. CENTER FOR SUBSTANCE ABUSE TREATMENT, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, FINAL REPORT, NATIONAL TREATMENT IMPROVEMENT EVALUATION STUDY at 241 (1997), *available at* http://www.icpsr.umich.edu/SAMHDA/NTIES/NTIES-PDF/ ntiesfnl.pdf. Treatment for drug and alcohol addiction is also one of the most cost-effective tools in the nation's continuing struggle to reduce and eliminate the market for illegal drugs. *See* C. Peter Rydell and Susan S. Everingham, Controlling Cocaine: Supply Versus Demand Programs (Rand 1994).

B. Addiction Treatment Services Are Underutilized.

Addiction treatment services are frequently underutilized – that is, in the aggregate those afflicted with diseases of addiction seek and receive treatment at a level that falls far below the level that would provide the greatest cost savings. Diseases of addiction are, by their very nature, characterized by denial, and often carry a strong social stigma. Many who need treatment do not seek it, or do not seek it early enough. As noted in the White House's most recent National Drug Control Strategy report, "according to a survey by the Department of Health and Human Services, the overwhelming majority of drug users who need treatment fail to recognize it .... Of the estimated five million individuals who needed but did not receive treatment in 2001, fewer than 8 percent felt they actually needed help." THE WHITE HOUSE, NATIONAL DRUG CONTROL STRATEGY 18 (Feb. 2003). There is therefore a "crucial need to get people into treatment – no small matter when dealing with an illness whose core characteristic is denial." *Id.* As the 1993 President's Commission concluded, the underutilization of addiction treatment services "perpetuates the health care spending on addiction related accidents and illness and limits capturing of health care savings through the treatment of the primary illness." PRESIDENT'S COMMISSION – TREATMENT at 81.

This is one reason why the National Alliance's Model Laws, and the laws of many states, *require* treatment as part of the criminal justice system. *See, e.g.*, MODEL CRIMINAL JUSTICE TREATMENT ACT §§ 5-8, set forth in PRESIDENT'S COMMISSION – TREATMENT at 151-61 (providing for court-ordered assessment and treatment, for offenses involving drugs or alcohol); *see also* 2003 Pa. Legis. Serv. Act 2003-24 § 16 (West) (to be codified at, *inter alia*, 75 Pa. Cons. Stat. §§ 3814-

15) (mandatory treatment after a repeat conviction for drunk driving); 625 ILL. COMP. STAT. ANN. § 5/11-501(e) (court-imposed treatment after drunk driving conviction). It is also one important reason why many states have enacted laws that require health insurers to provide or make available coverage for addiction treatment.[2]

The same factors that drive underutilization also mean that managed care missteps, or misconduct, have the potential for enormous adverse consequences. For example, a person with an alcohol problem who is beginning to experience the physical symptoms of withdrawal is not likely to remain in a treatment center's waiting room for hours, while awaiting a precertification decision from a managed care company. And an addict who seeks treatment one day may – if the treatment does not start that day – return to active use and active addiction. A stark and particular example of this is found in the facts underlying *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49 (D. Mass. 1997). The relationship between managed care and addiction treatment has also been noted in the policy literature. *See, e.g.*, Shelley Steenrod *et al., Effects of Managed Care on Programs and Practices for the Treatment of Alcohol and Drug Dependence*, 15 RECENT DEVELOPMENTS IN ALCOHOLISM 51, 67 (2001) ("Our review of managed care's influences on alcohol and drug abuse treatment systems finds

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[2] *See, e.g.*, HAW. REV. STAT. § 393-7(c)(6) (1993); 215 ILL. COMP. STAT. ANN. § 5/367(7) (West 1992); MD. CODE ANN. INS. § 15-802 (2002); MICH. COMP. LAWS ANN. § 500.3425(1) (2002); MISS. CODE ANN. §§ 83-9-27 to -31 (1972); N.J. STAT. ANN. § 17B:26-2.1 (1996); OHIO REV. CODE ANN. § 3923.29 (Anderson 2002); 40 PA. CONS. STAT. ANN. §§ 908-1 to -8 (1999); S.C. CODE ANN. § 38-71-737 (2002); TEXAS INS. CODE ANN. § 3.51-9 (Vernon Supp. 2004); *see also* MODEL ADDICTION COSTS REDUCTION ACT §§ 1-14, set forth in PRESIDENT'S COMMISSION – TREATMENT at 23-29 (requiring addiction treatment coverage).

evidence of systemic reductions in access to inpatient care and increased reliance on outpatient services.").

When an opportunity for effective treatment is lost, it is often the states that bear the burden. Most directly, this often results in a cost shift from private insurers to public funding sources, imposing costs on both publicly funded treatment resources and the criminal justice system. As set forth in PRESIDENT'S COMMISSION – TREATMENT, in the section addressing managed care:

> Cost shifting is already occurring here. In some cases, treatment already covered by insurance and paid for by the patient or the patient's employer is being shifted to public funding sources such as Medicaid, block grant monies and other state funding. Others go untreated altogether with the predictable societal costs of increased medical expenses, lost jobs with resulting unemployment and welfare costs, broken families and ultimately, crime.

PRESIDENT'S COMMISSION – TREATMENT at 82.

For these reasons, states have occasion to be extremely vigilant about any barriers to addiction treatment, including barriers that may be presented by managed care. In recognition of the direct effect that managed care decisions can have on a patient's course of addiction treatment, some states have enacted laws that not only require an addiction treatment benefit, but also impose requirements on the procedures and standards of the managed care organizations that decide whether or not the insured will receive care in a particular instance. Pennsylvania's law, for example, has been interpreted by its Insurance Commissioner as placing treatment placement decision in the hands of a treating physician, not the

managed care organization. Pennsylvania Department of Insurance Notice 2003-06, 33 Pa. Bull. 4041 (Aug. 9, 2003); *see* 40 Pa. Cons. Stat. Ann. § 908-4 (1999). For another example, the Model State Laws promulgated by the National Alliance require that managed care organizations use particular criteria and establish and follow certain specified procedures. MODEL MANAGED CARE CONSUMER PROTECTION ACT §§ 1-19, set forth in PRESIDENT'S COMMISSION – TREATMENT at 87-95; *see also, e.g.,* MD. CODE ANN. INS. § 15-10B-07 (2002) (qualification standards for utilization review physicians making substance abuse treatment decisions).

If states are permitted to endorse or pursue these policy protections, they should also be permitted to enforce them. Otherwise, these laws risk becoming empty gestures. This concern is not chimerical, as demonstrated by the numerous voices raising concerns about the effect that managed care has had on access to addiction treatment, even in states with powerful mandated-benefit laws. *E.g.,* LEGISLATIVE BUDGET AND FINANCE COMMITTEE, PENNSYLVANIA GENERAL ASSEMBLY, DRUG AND ALCOHOL TREATMENT SERVICES IN A MANAGED CARE ENVIRONMENT 16-25, 25 (Feb. 2003) (noting that the involvement of commercial managed care has resulted in shorter residential treatment stays, and observing that "it is clear that the average lengths of stay for inpatient rehabilitation . . . do not begin to approach the minimum coverage provisions (30 days) set forth in [40 Pa. Stat. Ann. § 908-4]"); Steenrod *et al, supra*.

The National Alliance is not, of course, asking this Court to take a position on the numerous policy issues discussed in the preceding paragraphs. Rather, the point is that these are serious policy drivers that are supported by significant evidence, and state legislators and state courts are, and should

continue to be, guided by their own analysis of the evidence, their own conclusions, and their own solutions.

III. The Relationship Between Diseases of Addiction and ERISA Preemption

Diseases of addiction, and the policy issues referred to above, shine an important light on two facets of the issue now before the Court.

First, and most fundamentally, the supposed cause-and-effect relationship between care that is actively managed by an insurer and lower health care costs is not as straightforward as Petitioners and their *amici* suggest. It is not universally true that every effort to expand medical treatment will increase health care expenditures. Quite to the contrary, effective drug and alcohol addiction treatment will on balance save health care costs, and also save society significant other costs.

Second, the experience with diseases of addiction demonstrates that managed care health insurers are not always in the best position, or even in a good position, to make utilization review decisions that result in the lowest health care costs. If this were so – and if the policy literature referred to above is correct – the managed care industry would readily embrace effective addiction treatment, and there would be no need for any state, ever, to mandate coverage for such treatment. That plainly has not happened, and state governments have found it necessary to require such coverage.

In order to understand one of the possible reasons why there may be a disconnect between the health care cost benefits of addiction treatment and a health insurer's posited motivation to lower health care costs, it is important to consider in more detail the structure of how behavioral health benefits are usually managed. Behavioral health care (a category that

frequently includes addiction treatment) is "very often identified and treated differently – mostly through behavioral carve-out or carve-in arrangements." Melek, *supra*, at 4. Thus, these medical decisions will be made not by the HMO or managed care insurer, but by another company that has contracted with the HMO or managed care insurer to make those decisions. "The behavioral healthcare organization is frequently capitated on a PMPM [per member per month] basis with **no** provision for risk sharing with the medical side of healthcare delivery." Melek, *supra*, at 4 (emphasis in original). As a result the entity making medical decisions that determine whether or not a patient receives addiction treatment (and determines what treatment they receive, how much of it, in what setting, and when) is often not in a position to reap the financial benefits that would eventually inure to the health insurer in the form of reduced medical care costs for the addict and his or her family. To the contrary, the decision maker stands only to reap the more direct economic benefits that any capitated provider receives by providing **less** care. *See generally Pegram*, 530 U.S. at 218-221. One researcher, analyzing the results from a single large employer, found that following the shift from HMO's to a single behavioral health carve-out contractor, the use of inpatient addiction treatment services per 1,000 members declined from 10.6 before the transfer to a carve-out contractor, to 5.5 in the first year after the carve-out, to 2.5 in the second year. Bradley Stein, M.D., M.P.H., *et al., Substance Abuse Utilization under Managed Care: HMOs Versus Carve-Out Plans*, 26 JOURNAL OF BEHAVIORAL HEALTH SERVICES & RESEARCH 451, 452 (1999).

Furthermore, many of the costs of addiction are borne not by the health insurer at all but rather shifted to society as a whole. This makes it even less certain that managed care insurers will, on their own, inevitably make those decisions that best serve the public health and safety interests referred to above.

Again, the National Alliance is not asking the Court to endorse any particular view on the economics of health care. Rather, the National Alliance seeks to alert the Court that these are difficult and important policy issues that states must be free to consider, evaluate, and respond to as they see fit.

IV. This Court Should Not Foreclose the Rights of States To Enact and Enforce Effective Drug Control Laws.

The National Alliance urges caution when the Court considers the scope of preemption under ERISA section 502.

Petitioner Aetna, in particular, advances a newly expansive interpretation of preemption under ERISA section 502, 29 U.S.C. § 1132, which could drastically curtail the range of policy options available to states. Petitioner Aetna is quite candid about this: under its interpretation of section 502 states can pass addiction treatment laws but are, whenever an ERISA plan is involved, extremely limited in their ability to enforce them. "[W]here the States are foreclosed from regulating is in prescribing additional *remedies* for breach of those state-mandated obligations." Petitioner Aetna's Brief at 47 (emphasis in original). This cannot and should not be the law, and such a broad holding here would be inconsistent with the earlier pronouncements of this Court.

As this Court stated in *Pegram*, "in the field of health care, a subject of traditional state regulation, there is no ERISA preemption without clear manifestation of congressional purpose." 530 U.S. at 236. No such purpose can be found here. Section 502 does not even mention, let alone preempt, substantive legal rights that exist outside of and independent of ERISA. Consequently, preemption of a state's right to pursue and **enforce** important public policy choices would also be improper.

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987) and *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987) have been addressed extensively in the briefs of Petitioners and will doubtless be covered in the brief of Respondent. For present purposes, it is sufficient to emphasize the factual context of those cases: both clearly revolved around a claim for benefits, not substantive rights that were established by state law and existed independent of any ERISA plan. *See Metropolitan Life*, 481 U.S. at 61 (the relief that plaintiff was seeking in his complaint included "reimplementation of all benefits"), *Pilot Life*, 481 U.S. at 43 (referring to the plaintiff's "state common law tort and contract actions asserting improper processing of a claim for benefits under an insured employee benefit plan"). Interpreting those decisions in a manner that would foreclose meaningful state regulation of managed care, and that could potentially foreclose state policy choices in this important area, is a result that is not dictated by those decisions and is not supported by the principles or statutory provisions that underlie them.

CONCLUSION

For the reasons set forth above, the National Alliance urges an interpretation of ERISA preemption that allows states to proceed with their efforts to fashion cost-effective, and effective, drug control policy.

Respectfully submitted,

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